

Fleet Public Health

Navy Environmental Health Center, Norfolk, VA



Navy Environmental and Preventive Medicine

Unit No. 2, Norfolk, VA - Unit No. 5, San Diego, CA - Unit No. 6, Pearl Harbor, HI - Unit No. 7, Sigonella, IT

Vol. 2, No. 1, January 1997

NEPMU-7 Sigonella, IT Edition

Route To:

Animal bites revisited: Monkeys and their viruses

NEPMU-6 has received several Disease Alert Reports (DARs) in recent months concerning monkey bites. These DARs concerned bites received in bars during port visits in Thailand. In no case was there appropriate wound care or medical attention immediately after the bite.

Two very serious conditions come to mind after such an incident. Of course, the first is rabies. The Armed Forces Research Institute of the Medical Sciences (AFRIMS) in Bangkok confirms that there is rabies in monkeys in

Thailand. Whether a bar monkey has ever been confirmed to have the disease is hard to discern. The conservative position of yes, possibly must be adopted, unless of course the monkey can be found and tested. This tack would pose a number of logistical and other problems, such as delay in post-exposure treatment. In one DAR, the sailor did not even know what bar he was in when he incurred the bite. The ship was already underway when the

Continued on page 8

CNO Occupational Health support survey

Several weeks ago NEPMU-7 received a letter from the Chief of Naval Operations with an Occupational Health Support Survey questionnaire. This survey, developed by the Occupational Health Quality Management Board under the NAVOSH Strategic Plan, should have been received by all Navy occupational health providers. I would like to share with you our input to

Continued on page 3

Inside this issue ...

Animal bites revisited:	
Monkeys and their viruses	1
From the OIC	1
CNO Occupational health support survey	1
The magnificent seven	2
Joint Endeavor: detachment OIC overview	3
You callin' me a nit-picker?	4
MEDCEUR 96-2 Romania	4
A quick review of Tuberculosis.....	5
Entomology support for Operation Joint Endeavor	5
Review of disease cases: 1995	6
Additional notes on teaching through interpreters.....	7
Preventive medicine support: Operation Joint Endeavor	9
NAVOSH Program changes for forces afloat.....	10
Tiny game hunting (Part II).....	11
Hail and Farewell.....	12
From the SEA, NEPMU-6.....	12

From the OIC

Naval Air Station, Sigonella, Sicily was visited in December, 1996 by Admiral Johnson, our new Chief of Naval Operations. During his stop-over with us, he presented his vision and priorities for the future of the Navy. To paraphrase the Admiral's discussion, he envisions a forward thinking Navy which is already the best in the world and will get better. His priorities include people, innovation and leadership.

It occurred to me as I listened to the Admiral how closely aligned the leaders in Navy Medicine are with his vision for the Navy. The Medical Department everywhere is devising new ways, as VADM Koenig our Surgeon General says, to move electrons not people and to bring medical care to the deckplates. A truly remarkable example of this is digital telemedicine aboard

aircraft carriers, in which digitized x-rays and ultrasound readings can be instantaneously sent by satellite to a major medical center for a consult with a medical specialist. This innovative approach benefits the Sailor who gets improved quality of care and the Fleet by preventing unnecessary transport of patients back to the United States.

In the same manner, Navy Preventive Medicine is providing leadership to connect Navy, Army and Air Force people into joint preventive medicine teams. The Navy Environmental Health Center (NEHC), Norfolk, VA and her echelon four activities are in the forefront of this effort. This year, NEHC participated with the Army and the Air Force in Europe and the Persian Gulf for at least two major combined projects. A joint preventive medicine team from

Continued on page 2

FROM THE S.E.A.

The Magnificent Seven

NEPMU-7 is what is happening in Sigonella, Sicily. We are in the market for highly motivated/top notch PMTs to come on board and join a very successful group of hard-charging professional support personnel. Our mission is providing professional, technical, and operational assistance and training in preventive medicine and occupational health programs to military and civilian based communities.

Sicily offers a variety of cultural activities to include Greco-Roman theaters located in Taormina, ancient Greek ruins and catacombs in Siracusa, and the Jet-Set beaches of Palermo. You will also have the luxury of being home-based at NAS Sigonella (THE HUB OF THE MED), which is the center point for Space-A travel throughout Europe.

Our AOR (area of responsibility) includes 120 countries (20° west longitude to 70° east longitude) throughout Africa, Southwest Asia, and Europe. Our missions frequently place us in the midst of many of the U.S. Armed Forces high profile operations (e.g. Operation Continued Hope, Operation Assured Response, and Joint Endeavor) and Partnership for Peace exercises with former eastern block countries.

Issues to consider when joining the MAGNIFICENT SEVEN include: extensive travel, rapid deployments (within 24hrs), lengthy deployments, and limited child care. If you're up to the challenge and excitement of a fast paced command, join the MAGNIFICENT SEVEN team. We're looking for a few good PMTs. For more information on a tour that is both a challenge and career-enhancing, e-mail us at:

siglcoa@sig10.med.navy.mil
or phone DSN 624-4101 or Com 39-95-56-4101 call your detailee today!

COURTNEY O. ABRAMS, HMCS(SW/AW)
Senior Enlisted Advisor, NEPMU-7

From the OIC, Continued from page 1

Navy Environmental and Preventive Medicine Units (NEPMU), from Naval Hospital Corpus Christi, TX and from the U.S. Air Force, Europe Surgeon's office is supporting the Army in Tazsar, Hungary for Operation Joint Endeavor. The team provides all preventive medicine and industrial hygiene services for the entire Army operating force in Hungary and Croatia. At the same time, a NEHC Forward Deployed Medical Laboratory is set up at Prince Sultan Air Base in Saudi Arabia in a joint operation with U.S. Air Force epidemiologists for effective medical surveillance of American Forces in that theater.

Another initiative of NEHC and her NEPMU's is this Fleet Public Health bulletin. All the NEPMU's contribute informative and up-to-date articles, rotating the editorship for each issue. Recently, the highly professional "desktop publishing" of the smooth bulletin was transferred from NEPMU-6, Pearl Harbor, HI to NEPMU-5, San Diego, CA. The NEHC echelon fours will continue publishing this bulletin, and we hope it is useful for our Medical Department customers in the Fleet.

Please contact your nearest NEPMU for help and advice for issues involving public health or occupational health and safety. It is our mission to help you with information on ports you will visit, or to conduct surveys at your invitation aboard your ship or station. The Navy Environmental Health Center and its NEPMUs are standing by to assist the Fleet.

CDR J.A. McGinnis, MSC, USN
Acting Officer in Charge, NEPMU-7

LOOKING FOR INFORMATION ON:

CAREER DEVELOPMENT
PROFESSIONAL
ORGANIZATIONS
OCCUPATIONAL LITERATURE

VISIT THE NEPMU5
WEBSITE AT:

<http://trout.nosc.mil/-nepmu5/>

Fleet Public Health

Vol. 2, No. 1, January 1997

Fleet Public Health is published four times a year by NEPMU-6 (April), NEPMU-5 (July), NEPMU-6 (October) and NEPMU-7 (January). Responses, comments and suggestions for articles of timely interest are solicited. Articles submitted for consideration must be routed via the author's Commanding Officer or Officer in Charge. Send articles and correspondence to the appropriate publishing Editor.

NEPMU-2
1887 POWHATAN ST
NORFOLK VA 23511-3394

Officer in Charge
R. J. Thomas, CAPT, MC, USN
Editor
HM1 C. Collins

Phone: (757) 444-7671, DSN 564-7671
Fax: (757) 444-1191, DSN 564-1191
E-mail: nepmu2@wrair-emh1.army.mil
NAVENPVNTMEDU TWO NORFOLK VA

NEPMU-5
NAVSTA BOX 368143
3035 ALBACORE ALLEY
SAN DIEGO CA 92136-5199

Officer in Charge
J. Beddard, CAPT, MSC, USN
Publishing Editor
Ms. B. Zimmer
Phone: (619) 556-7070, DSN 526-7070
Fax: (619) 556-7071, DSN 526-7071
E-mail: nepmu5@trout.nosc.mil
NAVENPVNTMEDU FIVE SAN DIEGO CA

NEPMU-6
BOX 112 BLDG 1535
PEARL HARBOR HI 96860-5040

Officer in Charge
B. S. Mitchell, CAPT, MC, USN
Editor
HMC S. Farmer
Phone: (808) 471-9505, DSN 471-9505
Fax: (808) 474-9361, DSN 474-9361
E-mail: nepmu6@hq.pacom.mil
NAVENPVNTMEDU SIX PEARL HARBOR HI

NEPMU-7 SIGONELLA
PSC 824 BOX 2760
FPO AE 09623-2760

Officer in Charge
J. A. McGinnis, CDR, MSC, USN (Acting)
Editor
W. L. Howl, LT, MSC, USN
Phone: 39-95-56-4101, DSN 624-4101
Fax: 39-95-56-4100
E-mail: sigljam@sig10.med.navy.mil
NAVENPVNTMEDU SEVEN SIGONELLA IT

Operation Joint Endeavor: Detachment OIC Overview

This bulletin also has articles written by LT Rankin and LT Bush concerning this same deployment.

I want to ensure that all members receive recognition for their outstanding efforts, mention industrial hygiene and some lessons learned. Four personnel from U.S. Navy Environmental and Preventive Medicine Unit (NEPMU) No. 7 were part of this history-making team; myself, LCDR(sel) Steve Rankin, LT Jeff Bush, and HM1 Tamela Harrison. An eight-person team provided preventive medicine support to more than 6000 personnel from all services stationed in Hungary and Croatia north of the Sava River. As you might imagine, it was exciting, and it's very different working with another service like the Army. They use different acronyms, different forms and they've never heard of Navy expressions like a "wetting down". I spent half an hour one day explaining what Wog Day is all about.

Our detachment also included preventive medicine specialists from other Navy Environmental Health Center (NEHC) commands around the world. ENS Dan Goad traveled from NEPMU-5 in San Diego to assist with industrial hygiene; HMC Andre Speller from NEPMU-2 in Norfolk was Senior Enlisted Leader; HM1 Chris Lemon from NEPMU-6 in Pearl Harbor; and HM2 Constaldo Bush from Disease Vector and Ecology Control Center in Jacksonville, Florida. We were responsible for helping ensure disease-free food and water, good sanitation conditions and industrial hygiene support for five separate bases in the Taszar area. We were assigned to the Intermediate Staging Base (ISB), which the Army had designated as a way-station for troops leaving or entering the Bosnia-Herzegovina theater. With 15,000 or so troops leaving and 5,000 assigned to enter as a covering force, you can imagine that Hungary is a busy place. It is expected that all troop movement will be completed in time for Christmas.

This was my first experience working with the Army, for such a long deployment (for a NEPMU). I was very impressed with the professional attitude, and the Army's ability to move a large

number of people and vehicles so quickly. The NEPMU-7 Detachment traveled throughout Hungary, Croatia, and Bosnia, and saw thousands of troops and hundreds of military vehicles pass through the ISB. As of this writing, the redeployment of troops is not complete.

Many interesting problems we encountered are mentioned in the other articles. Our biggest obstacle was the requirement to have two personnel assigned to a vehicle, and the need for at least two vehicles to enter Croatia. These safety measures have obviously worked well, but they made providing preventive medicine support more difficult and time-consuming. Industrial hygiene support included observing and documenting working conditions, assisting with some interesting fuel and HAZMAT spills, and answering many questions. I am interested in sampling for organic vapors, so I did as much sampling for fuel handling as I could. We also tried to maintain a good awareness of the risks of carbon monoxide for the coming winter.

At this time the OIC for the NEPMU-7 Detachment is LCDR David Shiraishi of NEPMU-6; the Medical Entomologist is LT Daniel Szumlas of NEPMU-2, and the Environmental Health Officer is LT Lawrence Cummings of Naval Hospital Corpus Christi, Texas. History continues to be made with the addition of several U.S. Air Force personnel to the second team, who arrived in Hungary on 15 November; my team departed Hungary 20 November. The present team includes Capt Donald Hickman and Staff Sergeant Dennis Bryant, Ramstein Air Base Germany; Airman First Class Casey Sanders, Spangdahlen Air Base, Germany; Airman First Class Adrian Adams, Royal Air Force Lakenheath, U.K.; and Staff Sergeant Karen Fouser, Air Force Materiel Command, Wright-Patterson Air Force Base, Ohio. Although the personnel have changed, the mission remains the same, to support U.S. and NATO troops on the move.

Lessons learned? Moving people and gear on short notice is hard work, and

CNO Occ Health support survey...
continued from page 1

one of the four questions in the survey: What do you consider to be the most important occupational health services you provided to support your customers' mission? (Action, services and requirement in the delivery of occupational health support that you believe is the most important in supporting the customers' mission.) Sharing our ideas in this forum, I thought would not only be useful as a reminder of our mission, particularly for the newer or junior personnel, but also to our customers, the Fleet. They need to know that we are genuinely concerned with continuous improvement of our services.

1. Periodic industrial hygiene surveys to continually monitor recognized health hazards and to identify new, emerging problems and recommend controls early in a preventive rather than reactive manner.

2. Medical surveillance programs that promote a high state of personnel readiness, protect the health of our work force and, in the case of the civilian worker population, reduce workman's compensation costs.

3. Ready, deployable personnel to respond on short notice to any contingencies requiring our expertise in sometimes harsh military field and maritime environments.

4. Professional consulting on often complicated, highly technical and sometimes overlapping directives and regulations.

5. Interpretation of regulatory requirements which are usually intended for continuous daily work processes as they apply to military operations that are sometimes only conducted intermittently.

This is only a partial list of the support services provided by NEPMU industrial hygienists. I'm sure you can think of many more. Please, send in your input and don't miss out on this opportunity for improvement in the delivery of our services.

Amilcar Villanueva LCDR, MSC, USN
Industrial Hygiene Officer, NEPMU-7

Continued on page 5

You callin' me a nit-picker?

Have you ever been called a nit-picker? In Brooklyn there are women who make their living as nit-pickers. They make \$25-35 per hour. No, they are not obsessed with insignificant details; they literally pick nits, or lice eggs, from the scalps of children. Lice, also known as cooties or mechanized dandruff, are obligate, ectoparasitic insects. This means they must live on an animal host such as a human to survive. Lice are host-specific, which means that they will only infest certain animals. For example, there are many species of lice that infest birds, but no self-respecting bird louse would be caught dead (literally) on a human. So suffice it to say that you can't get lice from your dog or cat. Contrary to popular belief, lice cannot jump or fly. Their legs are made for grasping hairs, so the musculature is all wrong for jumping. As for flying, they have no wings, so they can't fly. There are three types of lice that infest humans: the head, body, and crab louse. This article deals primarily with head lice, though there are many similarities between the different human lice.

In the United States head lice are commonly found on school age children. Fortunately, they are not considered disease carriers. The reason children are more prone to infestations of head lice isn't because they are dirtier, it is because of how they interact with each other. They are more inclined to come in close physical contact when they play and often share their hats and combs. There is no apparent correlation with cleanliness or socioeconomic level. In other words, lice don't

discriminate.

The head louse is small, about 2-3 mm in length, and can be found grasping tightly to the hair shaft close to the scalp. It is a blood sucker and must feed frequently to survive. Therefore, they do not voluntarily leave the host except to bug (pun intended) someone else. They can only live off of a host for about 24 hours before they die. An adult female head louse lays about 150 or more eggs in her life - averaging about 10 eggs per day. The female louse lays her eggs by cementing them to the base of the hair shaft where it hatches in about a week.

Careful grooming and frequent shampooing, unfortunately, will not eradicate an infestation. The most effective treatment is a pesticide. Most pesticides used for lice come in the form of a shampoo, which can be purchased over the counter at any drugstore. Other formulations exist, such as cream rinses, topical lotions, and sprays. Usually the pesticide application must be repeated several times about a week apart to ensure that all lice are killed. In addition, as many nits as possible should be combed out using a nit comb, which usually comes with most insecticidal products for lice. Bedding and clothing should also be washed in hot soapy water. A precautionary note regarding pesticide usage: when using a pesticide always read the label and follow the directions exactly as they appear on the label. This is not only for health reasons, but it is the law. Definitely, do not use a pesticide that is not labeled for treatment of lice!

Continued on page 5

MEDCEUR 96-2 Romania

On 20-28 August, 1996, I had the opportunity to participate in the Medical Training Exercise in Central and Eastern Europe MEDCEUR 96-2, held in the city of Piatra-Neamt, Baltatesti, Romania. I was attached to the Alabama Army National Guard (AANG) who was tasked with providing emergency medical training to Romanian Medical personnel and to assist in an earthquake disaster scenario.

The AANG was composed of doctors and nurses of various specialties. I was their preventive medicine support. From the 20-26 Aug 96, ongoing lectures pertaining to disaster preparedness and emergency medical training were offered to the Romanian doctors, nurses, and medical students participating in the exercise.

The medical training included first response medical care to proper triaging of patients. Most of the Romanian medical personnel understood English,

but interpreters were readily available for translation.

On 28 Aug 96, the actual earthquake scenario took place. The entire town of Piatra-Neamt was informed of the drill and placed on alert. All Romanian government and public establishments were to respond as if it was the "real thing." Everyone involved appeared to know what to do when the sirens sounded off. I could hear explosions and see fire and smoke appear. There were rescue attempts from buildings and triaging of injured persons. At a local hospital, a mock ward was set up for receiving the injured and providing emergency care. The primary mission of the AANG at this point was to observe and evaluate the Romanian Emergency Care Program and to provide feedback on ways of improvement.

MEDCEUR 96-2 proved to be an exciting exercise and a great experience.

B. A. Cooper, HM2, USN
Preventive Medicine Technician,
NEPMU-7

READY FOR DEPLOYMENT?

...to identify mission-critical public health concerns?

... to contribute to the planning and practical management of preventive medicine operations from pre- to post-deployment?

Learning/field experiences in...

- Epidemiology - infectious diseases
- International health issues
- Civil unrest - urban warfare

Approximately **60 hrs. category 1**

CME continuing education credits
(AMA-approved)

ELIGIBILITY:

E-7 or above IDC and PMT
Medical Medical Service Nurse
Corps Officers
Navy Army Air Force Coast Guard
Navy/Army/Civilian agencies
Active duty and Reservists

Apply Now!!! Operational Preventive Medicine Course: 4-25 JULY '97
Quotas (619)556-7086 DSN526-

...nit picker ?, Continued from page 4

Proper use of pesticides is safe and effective for treating lice. If you have any questions regarding which to use, consult your physician or local pharmacist.

LT David M. Bartholomew, Medical Entomologist

dmbartho@hq.pacom.mil NEPMU-6

A Quick review of Tuberculosis

Tuberculosis is caused by mycobacterium tuberculosis. There are over 20,000 cases occurring in the United States annually, and tuberculosis kills approximately two million people worldwide every year. The World Health Organization estimates that one person is infected with the tuberculosis bacteria every second.

Tuberculosis screening by the Mantoux method skin test (Purified Protein Derivative, or PPD), is done every year or every three years, depending on the member's duty station and job. To ensure accurate

readings of the test, use the guidance provided in BUMED INSTRUCTION 6224.8, Tuberculosis Control Program and compare. Remember, the Bacillus Calmette-Guerin (BCG) Vaccine does not affect the interpretation of the results for a military member. This vaccine is given to children in some high-risk areas for tuberculosis prevention. A PPD test will react in these children, but the reaction commonly ceases to exist by the time the member is old enough to enlist. Don't forget that there are other things affecting the results, including the member's age, risk factors, birth country, HIV infection, and if the patient is a close contact of an active case.

If a patient has a positive skin test, Isoniazid (INH) may be prescribed. Close monitoring is needed to ensure that the individual uses the drug as prescribed and to identify any side effects from the treatment. Some people may also require an additional course of pyridoxine

Continued on page 7

Joint Endeavor... Detachment OIC Overview... Continued from page 3

takes a lot of preparation in advance of a sudden request to move. Being prepared for changes or obstacles at any moment is required. You get better at overcoming obstacles with experience. Clear communication is vital to getting things done when you're in a constantly changing situation, which this deployment was, from beginning to end. Of course, having the finest preventive medicine personnel to work together as a team sure helps. All the members deserve a lot of credit for the success of this mission. After four months with the Army, I also think we learned how to appropriately use the expression "hooah" in a conversation. I extend my best wishes for a successful and safe deployment to our preventive medicine personnel and all the fine people we met who are still deployed to Operation Joint Endeavor.

Jerry A. Formisano, Jr., LCDR, MSC, USN

Industrial Hygiene Dept., NEPMU-7

Navy Entomology support for Operation Joint Endeavor

The article written by U.S. Navy Environmental and Preventive Medicine Unit No. 7's (NEPMU-7) Environmental Health Officer, LT Jeff Bush, does a thorough job of introducing and outlining the deployment of the first U.S. Navy Preventive Medicine Team in support of Operation Joint Endeavor (OJE). To prevent unnecessary repetition, we recommend that you review his article also. Prior to this time, the field portion had been mostly a U.S. Army Operation, with the deployment of three Army preventive medicine units into the theater.

Being located at the Intermediate Support Base (ISB) in Taszar, Hungary, although a different environment, still required the same basic vector control and surveillance program as any fixed base facility. The Navy Team replaced the U.S. Army's 71st Preventive Medicine Detachment around 01 August 1996. The

Status Of Forces Agreement had been signed and the OJE Pest Control Contract had been in place for a few months. Therefore, vector surveillance was operated much like any shore station facility.

The program monitored pest problems and complaints. Minor problems, i.e., wasps or isolated rodent infestations, were dealt with directly by either consultation and education, or the team eliminated the problem. Quality assurance (QA) was applied to the local national pest controllers to ensure Environmental Protection Agency guidelines were observed and that pesticides were applied in the most efficient, effective manner. By Hungarian law, only persons certified by Hungary were allowed to apply technical grade pesticides. Canned aerosols, such as D-phenothrin and Resmethrin, and baits

could be applied by Department of Defense certified team members.

Working with the local pest contractors proved to be rewarding and challenging. They were always professional and were open to suggestions on application techniques or areas to be treated. However, there were three methods from which requests for pest control support could be forwarded and those sources were: a) the Director of Engineering and Housing, the Army's equivalent to the Navy's Public Works Department, b) the Hungarian's Ministry of Defense, and c) the Brown and Root Contracting office, which was available, if all else failed. Notification that a request had been forwarded, or to whom, was often untimely, making consistent QA difficult.

Upon arrival in Hungary, the major vector problems tended to be wasps and bees. Traps were constructed using clear plastic 2 liter water bottles with juice or syrup for bait. This proved to be highly effective for controlling foraging wasps and bees. Nesting sites were sprayed with D-Trans Allethrin-Resmethrin Flies

Continued on page 8

Review of disease cases:1995

OVERVIEW:

This bulletin summarizes the analysis of 381 Disease Alert Reports (DARs) received by NEPMU5 on active duty personnel, dependents, and retirees, with disease onset in CY 1995. The general geographic area covered is the western United States. DARs for personnel deployed to WESTPAC, IO, etc. routinely go to NEPMU6 or NEPMU7. During this period 379 DARs were received (211 Active Duty, 168 Dep/Ret) for 405 patients (231 Active Duty, 174 Dep/Ret). The DAR reporting system is a passive surveillance reporting system and suffers from the limitations of all such systems. The principle limitation is significant; under-reporting of the diseases of interest. The Disease Alert Reports instruction, in effect during this time period, was NAVMEDCOMINST 6220.2A, which has since

been superseded by the publication of BUMEDINST 6220.12 dated 19 Apr 96 (NSN 0510-LD-005-8330).

Table 1 shows the distribution of 405 total cases by DAR reporting diagnosis. The miscellaneous category consists of single cases of: LGV, Guillain-Barré, Strep. fasciitis and mononucleosis (for Active Duty), and one case of food-borne botulism, and two cases each of listeriosis and toxic shock (for Dep/Ret).

DISCUSSION:

For active duty personnel 87% (201/231) of the conditions reported for 1995 have effective preventive strategies. Safe sexual practices have the potential to prevent much Hep B/C, Syphilis, and LGV (42 cases reported in these areas). Proper food handling and personal hygiene will eliminate most salm/shig/campy, Hep A, giardiasis, brucellosis, and amebiasis (59 cases). Diligent employment of personal protective measures (malaria and Lyme), use of antibiotic prophylaxis (malaria), and a heavy dose of common sense (animal/snake bites) could sharply reduce the 16 cases in

Table 1

1995 NEPMU5 DARs By Disease Diagnosis And Patient Eligibility Category

DIAGNOSIS	Active Duty	Dep/Retirees	Total
Bites	9	1	10
Cocci/Histo info only)	5	3	8
Salm/Shig/ Campy	34	36	70
Hepatitis	35	24	59
Malaria	4	1	5
Meningitis	25	47	72
Syphilis	24	12	36
Tuberculosis	5	21	26
Varicella	73	0	73
Pertussis/ Measles/Mumps	2 (Mumps)	17 (13/1/3)	19
Giardia	5	5	10
Other Parasitic	2	8	10
Miscellaneous	4	5	9
TOTALS	231	174	405

these categories. Vaccine-preventable diseases reported (in addition to Hep A/B discussed above) included mumps (2 apparent vaccine failures) and varicella (73 cases). A recent message BUMED 241901Z JUN 96 provides interim guidance on the use of varicella vaccine. Current guidance is to give this vaccination to susceptible health care workers and it is strongly recommended for susceptible adolescents and adults living or working closely with immunocompromised individuals. Additionally, all susceptible recruits will be immunized with a two-dose regimen. The average time lost from work is approximately 10 days for this disease. These data also show our need to continue to work on TB screening. The threat to active duty personnel continues to be from their dependents. By maintaining our vigorous screening program we can identify personnel at risk early and make appropriate interventions. **Table 2** provides a historical comparison of diagnoses by category for 1994 and 1989 DAR data

previously published by HM1 Magcalas in the Fleet Health Bulletin Vol.1. No. 2, June 1995.

This comparison shows that total DAR reporting has decreased significantly in the last year and when compared to five years previously. However, if you subtract the varicella cases for 1995 (231-73=158) and 1994 (474-272=202) the difference in the numbers of reported diseases is much smaller. A significant decrease in hepatitis incidence may have occurred in the last year. Subtracting varicella to compare 1995 cases with 1989 cases (613-314=299) also seems to show a decrease in hepatitis cases. There may have also been a decrease in syphilis cases during this period. We may also be seeing an increase in infectious diarrhea. However, this comparison does not account for differences in the size of the Navy in our AOR during this period.

SUMMARY:

DAR reporting (with the exception of varicella) has remained

Continued on page 7

Table 2

NEPMU5 Active Duty DARs Comparison By Selected Category

DIAGNOSIS	1995	1994	1989
224TOTAL CASES	474TOTAL CASES	613 CASES	
Bites	9	7	1
Hepatitis	35	51	126
Malaria	4	4	8
Meningitis	25	23	20
Salm/shig/campy	34	29	18
Syphilis	24	29	49
Tuberculosis	5	5	7
Varicella	73	272	314

fairly constant over the last few years. We may be seeing a tendency toward less syphilis and hepatitis in our active duty population and an increase in infectious diarrhea. However, the ability to more exactly characterize this change (if any) is prevented by the absence of information on the total population size during these periods and lack of data that could tell us what percentage of DAR reportable conditions are being reported.

HM1 Jackson, Epidemiology Dept. NEPMU-5
LCDR Sherman, PH/GPM Residency USUHS

Additional notes on teaching through interpreters

Teaching in a foreign country can be extremely gratifying, and fun. Professional colleagues from around the globe are always delighted to hear from others in their field. If you are not fortunate enough to be conversant in your host country's language, then you'll certainly need a good interpreter to provide your student and colleagues with a valuable experience.

The following are additional points to supplement LCDR Cope's article in the October Fleet Public Health bulletin, and are based on our most recent experiences providing a disaster preparedness planning workshop in Bolivia:

Introductions; short and sweet. Too detailed an introduction will turn folks off in any country.

Interpreters; In many countries there is no effective certification system to determine how good interpreters and translators are. Checking with the American Embassy, the American Chamber of Commerce, and other locals can guide you to the best ones. You may be surprised at how few there are who are experienced at doing simultaneous interpretation, especially on scientific topics.

Vocabulary; If you are giving a presentation, provide a script of what you will say, or at least a listing of the more complicated and confusing terms. This will make the interpreter's, and your job easier. Meeting with the interpreter(s) in advance of a presentation will give them time to get used to your accent, if any.

Numbers; If you are using precise numbers i.e., very large or small numbers, write them down or on a board because thousands, millions and billions are sometimes spoken the same but written differently.

Equipment; Simultaneous interpretation through FM headsets is ideal. You can speak naturally, and the audience hears your presentation in their native tongue. Portable lapel microphones for both you and the interpreter allow you to adjust volumes so neither voice overpowers the other. Establish what signals should be used to increase or lower someone's voice. Make sure anyone in the audience speaks up if they have a question so your interpreter can hear.

Location; When listening to presentations, questions, etc., have the interpreter sit behind you and to the side so they can provide the interpretation without disturbing anyone else. You might want to provide the interpreter with a table or lectern.

Fatigue; Interpreters can usually manage periods of up to 45 minutes. If you will have several talks be sure to have at least two interpreters.

Slides; It makes it easier for your audience if you can provide slides with legends in the local language so you can provide additional commentary. If there is a difficulty hearing you or the interpreter they will at least be able to obtain the information presented on the slide or overhead.

A final note. Don't be surprised if a few of your hosts, after you've been working with them for a few days, give you some small tokens of appreciation. Keeping some "regalos" on hand (e.g., Navy tie tacs, cuff links, patches, etc.) will avoid the embarrassment of not having anything to provide in return. LCDR Cope points out that corps devices are particularly prized, easily obtained from the exchange system, and certainly unique.

Have fun out there!

CDR Konrad Hayashi and CDR Robert Rendin, NEHC

A Quick review of tuberculosis Continued from page 5

(vitamin B6). Only a one month supply of INH should be given out at a time to make sure that the patient comes in and receives the monthly evaluations. After the treatment is over, yearly evaluations

must be done to review the signs and symptoms of tuberculosis with the patient, because the treatment does not eliminate the disease, it only lowers the risk of the disease occurring.

If an active case of tuberculosis is discovered, a Disease Alert Report (BUMED INSTRUCTION 6220.13) must be initiated. A contact investigation must also be performed. This includes

several things, such as investigating the patient's health record, a history of previous travel, and screening those personnel who have been in recent close contact with the individual. Active tuberculosis always requires multiple drug therapy. Compliance with all prescribed medications is required for successful treatment. Drug resistance is a significant problem when treating tuberculosis. Preventive medicine, infectious disease and pulmonary medicine should work together to determine the most appropriate treatment regime. A copy of the Disease Alert Report must be sent to the cognizant Navy Environmental and Preventive Medicine Unit (NEPMU). Also, every year an annual

Continued on page 11

Entomology support for Operation Joint Endeavor, continued from page 5

were a minor problem in some of the dining tents, but due to constant sanitation and the use of some Fly Tech, they never became a major problem. The lack of rain had significantly reduced the mosquito population so that there was no initial problem. Mice were an occasional irritation and ticks were never heard from. Spider bites were not reported until mid-November but ants proved to be a constant problem in the dining tents at Slavonski Brod, Croatia. The ants were satisfactorily controlled by the local pest contractors.

After an unusually wet Labor Day weekend, which surpassed the September rainfall prediction, followed by very cool weather, a substantial mosquito population bloom occurred around the last week of September and ran through mid-October. Timing the mosquito bloom at the end of the fiscal year, coupled with the Hungarian certification requirements, was a major coop for the culicids. Mosquito breeding sites had been consistently controlled inside the area ISB sites, but external sites were off limits. Local contractors provided some relief through the Ultra Low Volume application, but application was limited due to available funding. This resulted in a significant emphasis on the use of personal protection and cases of deet cream, permethrin fabric treatment and D-phenothrin were made available to the troops, sailors and airmen.

One of the responsibilities of the team was to inspect the billeting and dining facilities contracted for the Military Police (MP) platoons responsible for patrolling the deployment/redeployment routes from Slovanski Brod, Croatia to Taszar, Hungary. This included rodent and arthropod pest surveillance at each of these locations.

Generally, these locations were satisfactory, meeting U.S. Standards. However, one location was a consistent potential health threat from food preparation facilities and rodent infestation. The facility was reported to be over 400 years old and was in need of

maintenance. The rodent problem had been brought under significant control, but there was substantial evidence that this would be a continuous battle. No preventive medicine personnel had been consulted prior to the awarding of this contract in the winter of '96, and it proved difficult to correct the oversight. Eventually the MP platoon relocated to a more modern facility to the satisfaction of all Implementation Forces parties.

The redeployment introduced new questions on retrograde wash down requirements. United States Department of Agriculture (USDA) standards were used for vehicles returning to the US, but no standard has been developed for vehicles and equipment returning to the European central region. Additionally, Foot and Mouth Disease (FMD) was reported in Macedonia and Albania, and the potential threat of FMD introduction was a reoccurring topic of discussion. The team entomologist, a USDA green card carrying member, was tasked for consultation and worked closely with the 72nd Medical Detachment Veterinary Officer. This team helped to provide quick expertise and needed guidance on the FMD threat, cleaning standards and procedures, including guidance on the development of cleaning standards for non-US bound vehicles and equipment.

LT Rankin was replaced by LT Daniel Szumlas, who arrived in theater on 15 November. LT Szumlas, an Entomologist from Navy Environmental and Preventive Medicine Unit No. 2, took over the Task Force 67 vector surveillance and control responsibilities and continued to march on smartly.

With a smile on our faces and our gear in our packs, We boarded a C-130 for a welcomed trip back. We taxied the runway and flew out of sight,

Happy Holidays to all and to all, a Good Night.

Steven E. Rankin, LCDR(sel), MSC, USN
Medical Entomology, NEPMU-7

Animal bites, continued from page 1

patient was first seen by his Independent Duty Corpsman (IDC).

After arriving at the conclusion that the animal causing the bite or scratch could possibly have been infected, the course of action is clear. Thorough wound cleansing (vigorous scrubbing with soap and water for at least 5 minutes) immediately after the injury is essential, and ideally will have been done. In one of our cases, there was NO wound care for 48 hours. If the wound is deep or ragged, surgical debridement is indicated. Next is starting the rabies vaccine series with the human diploid cell vaccine (HDCV). The full series includes 1.0-ml IM (in the deltoid for adults and children) doses at 0, 3, 7, 14, 30, and 90 days. Human rabies immune globulin (HRIG) is given 20 IU per kg of body weight, with up to half being injected into the region immediately around the bite. Some anatomic areas may not be able to accept half of the amount safely, since it could be as much as 5.0-ml or more. The remainder is given IM in the gluteal region. HRIG should be given when the first vaccine dose is given, but can be given up to 7 days after starting the vaccine series. It is essential for these measures to be started early. The incubation period for rabies is usually 3 to 8 weeks, but has been as short as 9 days. If symptoms of rabies begin before starting post-exposure prophylaxis, there is very little chance of survival.

The second, and more exotic, condition of concern is Herpes B infection. This is a virus closely related to Herpes simplex virus (HSV) which infects various species of macaque monkeys, including rhesus and cynomolgus. The infection is very mild and can be persistent in these animals, but if acquired by a human host through a scratch or a bite, it is likely to be fatal. Infection in humans is rare; only about 40 cases have been documented. Most of those individuals died, however. Manifestations of infection in humans include vesicles at the bite site, diffuse pain, fever, headache, regional lymphadenopathy, sensory and motor dysfunction, seizures, paralysis, and death. The incubation period can be as short as two

Prospective Authors:

Have any suggestions? Interested in contributing?
Send your articles/comments in now! See page 2 for more information.

Continued on page 10

Preventive Medicine support: Operation Joint Endeavor

In July of 1996, U. S. Navy Environmental and Preventive Medicine Unit No. 7 (NEPMU-7) was tasked to relieve the existing preventive medicine assets in Hungary in support of "Operation Joint Endeavor". The replacement team consisted of two Industrial Hygienists, a Medical Entomologist, an Environmental Health Officer and four Preventive Medicine Technicians (PMTs). NEPMU-7 provided four members of the team while the rest were augmented from other NEPMUs and the Disease Vector and Ecology Control Center, Jacksonville, Florida.

The team arrived in late July, seven months into the operation. The existing preventive medicine unit was the Army 71st Medical Detachment out of Wuerzburg, Germany. They arrived in the middle of December 1995 after the Dayton Peace Accord was signed and NATO troops deployed to the region. The 71st was responsible for laying the preventive medicine groundwork for the operation in Hungary and part of Croatia. In the middle of Eastern Europe's worst winter in decades, this was no easy task.

The turnover with the 71st lasted approximately two weeks. The usual meeting of contacts and orientation to the facilities throughout the Intermediate Support Base (ISB) in Hungary and operations in Croatia was foremost on the agenda. The preventive medicine concerns involved eating establishments, water/wastewater systems, habitability and epidemiology. An immediate challenge of the operation was becoming familiar with Army's instructions, inspection forms and correspondence. Since this was an Army operation we decided to stay with what was most familiar to our constituents in theater instead of using a Navy format. With a few exceptions the Army's instructions are actually not that much different than the P-5010. The inspection forms required a little getting used to but once the PMTs adjusted to them, it was not considered a problem.

The reception of a Navy preventive medicine team in theater was positive. With the exception of a few individuals we were the only Naval personnel in theater. Aside from a little good natured ribbing the working relationship with our Army constituents was friendly and professional. The 71st Medical Detachment departed the theater in early August. From that point on, the NEPMU-7 Detachment had preventive medicine responsibilities in Hungary and Croatia. Croatia proved to be a logistical problem, due to the requirement of a minimum of a two vehicle convoy to travel anywhere in the country. The inspection requirements in Croatia were Military Police (MP) Stations located along transportation routes to and from Hungary. These stations were located in civilian hotels, where MP personnel were berthed. Inspections were performed on the dining facilities in hotels which provided meals and a general berthing inspection. Inspections were performed on a monthly basis, according to contract requirements with the facilities. When the operation began, these MP sites were established without preventive medicine involvement; As a result, there were concerns after the facilities were occupied. With the cooperation of the Army's contracting officials, we

were able to include preventive medicine review and inspection prior to contracting with these facilities.

Sampling of water systems throughout the ISB was a continuous program. For the most part, the water systems serving the military installations in Hungary and Croatia met drinking water standards. Routine Colilert testing revealed periodic problems resulting in positive total coliforms sample results. This usually occurred when chlorination systems were not being maintained properly. The water sources were ground water from civilian public water systems providing water to installations in the ISB.

A drinking water source was established early in the operation that utilized a Reverse Osmosis Water Purification Unit (ROWPU) followed by a contracted bagging system. This operation was located in Kaposvar, Hungary and used the public water supply as its source. The bagged ROWPU water was then distributed to dining facilities throughout the ISB where it was available to all personnel. The only problem with the bagging system was the short shelf-life of the product, due the fact that the chlorine content reacted with the plastic bags producing a bad taste over time. The Army veterinarians established a thirty day shelf-life for the bagged water to avoid the bad taste issue.

The communicable disease program was not functioning when we arrived. The community health nurse position at the 67th Combat Support Hospital (CSH) was vacant for a number of months prior to our arrival. The 67th CSH provided primary medical care for U.S. military, civilians and contractors in the ISB. The community health nurse performed epidemiological surveillance and follow-up for army medicine.

Our team assumed this role and soon began receiving referrals for sexually transmitted diseases (STDs) from the 67th CSH. The STDs consisted of a mix of gonorrhea, syphilis, chlamydia and genital herpes. The difficulty in conducting an STD program in that environment was the constant movement of personnel in and out of the ISB. Contacts were difficult to trace and follow-up.

We periodically received requests from the Army Morale, Welfare and Recreation (MWR) coordinators to perform inspections on local civilian recreation facilities for U.S. personnel to utilize during their free time in the ISB. Most of these facilities were swimming pools, actually natural hot spring water spas, which are popular in Europe. Unfortunately these hot water spas did not meet U.S. military standards as far as water quality is concerned. Most of these facilities were disapproved for use by our detachment. MWR did locate some chlorinated swimming pools which did meet standards and were therefore approved. The major emphasis as far as

Continued on page 10

Download *Fleet Public Health*

Fleet Public Health will soon be available from the NEHC homepage. For information on downloading an electronic version, check the NEHC site at:

<http://ehc40.med.navy.mil>

NAVOSH Program Changes for Forces Afloat

In June of 1996 it was anticipated that the distribution of OPNAVINST 5100.19C change 1 would be completed by 31 December 1996. The CNO will notify us of the implementation date of the change. The change provides: guidance on afloat mishap investigation and reporting in one document, new information on the control of shipboard polychlorinated biphenyls, information on consolidated hazardous material reutilization and inventory management program (CHRIMP) for ships, information on the operation of shipboard incinerators, and new standard operating procedures for shipboard asbestos operations.

Some notable revisions are seen in Chapter A6, Mishap Investigation and Reporting. Sections are added on responsibilities, training and several appendices on concept of privilege, mishap investigation board administration, reportable explosive mishap or conventional ordnance deficiency report, motor vehicle reporting procedures, diving mishap and hyperbaric treatment reporting procedures, off-duty recreation, athletics and home mishap reporting procedures and advice to witnesses.

Chapter B1, Asbestos Control Program is also visited with changes. They are found in new appendices on replacement of asbestos-containing gasket/packing material standard operating procedures, limited asbestos floor tile removal standard operating procedures, and preventive maintenance on brake assemblies standard operating procedures.

A hazardous material minimization center (HAZMNCEN) section is described in Chapter B3, Hazardous Material Control and Management Program. HAZMNCEN procedures are presented in Chapter C23 Hazardous Material Storage Use and Disposal Precautions. Guidance on fire watch manning was added to Chapter C11, Welding Cutting and Brazing. A new section on shipboard incinerators is incorporated in Chapter C13, Machinery.

The Polychlorinated Biphenyls

(PCB) chapter, Chapter B14, will now include sections on responsibilities, program elements, identification of PCBs and PCB-containing materials, control of PCBs in the shipboard workplace, medical surveillance program, environmental contamination and training. References are cited and appendices include a PCB checklist and PCB labels.

These are just some of the major changes. Many other changes in subsections are not noted here. The purpose of the changes are to provide modifications to regulatory requirements, embody lessons learned from mishaps, and incorporate changes recommended by the Fleet, which will enhance the NAVOSH program.

W. L. Howl IV, LT, MSC, USN
Industrial Hygiene Department, NEPMU-7

Preventive Medicine Support, **Continued from page 9**

preventive medicine was concerned was during the redeployment of personnel from Bosnia-Herzegovina and Croatia through the ISB during the months of October through December. An estimated 15,000 troops were expected to travel from the south, through Hungary, back to their commands in Germany or elsewhere. Strict adherence to sanitary procedures concerning food service operations, berthing, water/wastewater systems and control of communicable diseases in general, were of prime interest during this period. Inspections were more frequent, which heightened awareness.

The 67th CSH provided influenza vaccinations to as many personnel in theater as possible. Hepatitis A vaccine was administered to troops as they were processed during the redeployment screening, back in the home bases.

Our team returned to our parent commands in mid November and was replaced with a joint Navy and Air Force team. The experience during this operation was rewarding. To participate in an operation with this much public

attention does not occur that often in one's career. It is my hope that the efforts of all U.S., as well as NATO, forces involved in this operation will result in a permanent peace in this region.

LT Jeff R. Bush, MSC, USN
Environmental Health Department,
NEPMU-7

Animal bites, continued from page 6

days. There is some evidence that high dose acyclovir can prevent or modify the infection if started promptly. However, there are numerous factors to consider, such as: whether the monkey is a macaque, whether it can be tested for B-virus, whether the injured person has symptoms consistent with B-virus infection, etc. Anyone in the Fleet evaluating an individual with possible B-virus exposure should obtain the help of an infectious disease specialist via the nearest NEPMU.

Of course, the preferred course of events for sailors and marines is to avoid bites by monkeys in the first place. Consider adding the dangers of monkey bites to your routine pre-deployment briefings, if your folks are headed to a part of the world where they may encounter these animals in the wild or in bars. Complete avoidance is the best precaution. Monkey bites are commonly on the face and head, which leads to an increased chance of developing rabies. Emphasize that immediate, vigorous wound scrubbing with copious soap and water is the first essential step for any animal bite. Next is prompt evaluation by medical personnel so that the risk of rabies and other infections can be evaluated, and rabies vaccine and HRIG administered if appropriate. Let's not lose any sailors or marines to this horrible, but completely preventable, disease.

CDR Jeff Yund
Epidemiology Department, NEPMU-6
ajyund00@hq.pacom.mil
(808) 471-9505; DSN 471-9505

Tiny game hunting(Part II):

Ants and cockroaches

ANTS - Don't be alarmed if you spot a few stray ants in your abode. Ants for the most part are considered beneficial insects. They are good biological controls of the pests we haven't been successful controlling on our own. They eat fly larvae, flea eggs, and flea larvae. They also go after cockroaches and cone nose bugs, a noble behavior on their part. Furthermore, ants patrol the perimeters of our houses and help keep termites, their mortal enemies, from establishing colonies in our homes. However, sometimes they become pests when they invade homes and establish nests. There are many different species of ants, but the most common house invader is the thief or grease ant. As the latter common name implies this insect prefers greasy or meaty foods. Carpenter ants are another familiar invader and are often mistaken for termites. Like termites some of these ants periodically develop wings and leave the colony in great numbers when forming new colonies. Carpenter ants live in wood and can be very destructive by chewing out burrows with their iron-like jaws.

Control - Sanitation is the key here. If you leave food bowls out for pets, consider placing the food bowl in a larger bowl partially filled with water, so an effective moat is achieved. To make this moat even more impassable add a little dishwashing soap. Ant bait traps also give good control for infestations. An effective and inexpensive method is to also zap invading ants with a solution of one tablespoon of dish detergent in a one quart spray bottle filled with water. Before killing off invading ants, try tracing the ants back to their point of entry. This is where you will want to stop them. Boric acid, turmeric, black or cayenne pepper products, or citrus oil, all form effective ant barriers if placed at the point of entry. Fine dusts such as boric acid, diatomaceous earth, silica aerogel, scratch away the protective, waxy, outer layer of the insect. Pour these products into cracks and crevices to eliminate ants.

COCKROACHES - By far cockroaches are the most loathed insect on Earth. There are several species of cockroaches, but the most common household roach is the German cockroach, *Blattella germanica*. It is easily identified by the two dark brown longitudinal stripes on its pronotum (the shield that covers its head). Cockroaches have been known to mechani-

cally carry many pathogens including salmonella, shigella, typhus, poliomyelitis. Their ability to transmit these organisms has never been clearly established. They have been implicated many allergic reactions in humans, because their brittle, discarded outer skin turns into a fine powder that is easily inhaled. Roaches like warm, moist, areas and seek the shelter of narrow cracks and crevices. Roaches are thigmotactic; they like to be touched by as many surfaces as possible, so they especially like stacks of newspapers and grocery bags. The female cockroach is a prolific breeder, and produces an egg case that is attached to her body. She can produce up to five egg cases in her lifetime, and each case may carry up to fifty young. Cockroaches are very adaptable, and consume the same foods that people do, but they can survive on wallpaper paste, soap, paper, dirty laundry, and other dead and live insects. They can also survive three months without food, and thirty days without water. For every cockroach seen out in the open foraging for food, there may be fifty to a hundred unseen lurking in the cracks or crevices of homes and ships. Cockroaches, like cats, groom themselves constantly, making them ideal candidates for ingesting boric acid, and silica gel.

Control - As always sanitation goes a long way towards cockroach control. Sticky traps can also be effective for reducing small infestations, and letting you know where the cockroaches are. Pheromones are added to some sticky traps to lure great cockroaches into them. Cockroach baits gives excellent control for large infestations and can be safely used in areas where pesticide cannot such as submarines and around sensitive electronic equipment. Bait stations should be placed close to where infestations and harborages are located, kept away from water, and changed every three months. Boric acid can be applied evenly over a wide area with a bulb duster. Boric acid can be toxic if ingested so it should not be used in areas where there are pets or small children. Even after decades of use cockroaches have not become resistant to it. Boric acid is also available in a gel form that can be caulked into cracks and crevices. Commercially available silica gel dust desiccates can also be applied around cockroach harborages. Biological controls are very effective and there are many creatures who thrive on cockroaches including wasps, scorpions, toads, and in the tropics, geckos.

HM1 L.F. Maranzana

Preventive Medicine Technician

Training Dept. NEPMU-6

Quick review of TB

Continued from page 7

tuberculosis summary record must be prepared by each activity with medical personnel. This report covers 01 January to 31 December and is due to your cognizant NEPMU by February 28.

If there are any questions that are not clearly answered by the BUMEDINST 6224.8, do not hesitate to contact your cognizant NEPMU for advice.

Robert F. Kabata, HM3, USN
Byron Hendrick, CDR(sel),MC, USN
Epidemiology Department, NEPMU-7

Help us help you!

Send any address corrections, changes, or deletions to:

OICNEPMU-5
ATTN FPH EDITOR
NAVSTA BOX 368143
3035 ALBACORE ALLEY
SAN DIEGO CA 92136-5199

Or send us the info by:

Comm/DSN FAX: (619) 556-7071/526-7071

Welcome Aboard!

NEPMU-2

CDR W.D. McBride, USHS

LTJG T.A. Badar, OIS, Newport, RI

Mr. R. Morin, NM C, Portsmouth, VA

HM1 D.A. Evans, USS Stout (DDG 59)

HM1 F.V. Johnson, NAVHOSP, Jacksonville, FL

HM2 J.A. Area, USS Mississippi (CGN 40)

NEPMU-5

CAPT P. Olson, MC, USN, NAVMEDCTR, San Diego, CA

CDR N. Lacy, ADDU NAVMEDCTR San Diego, CA

HM1 J. Mendiola, NAVMEDCTR San Diego, CA

HMC S. Black, , San Diego, CA

HM1 J. Weigel, USS Ogden, LPD-5

HM2 A. McCabe, USS Constellation.

NEPMU-6

None

NEPMU-7

LCDR Amilcar Villanueva, MSC,

USS Shenandoah (AD-44)

Fair Winds and Following Seas!

NEPMU-2

HMC M.E. Bankard, USS George Washington (CVN 73)

HMC C.P. Jackson, Retired

HMC A.G. Speller, East Coast Food Mgmt. Team

HM1 M.J. Neilsen, Retired

HM2 N.O. Stift, BMC, Sasebo, Japan

HM3 H.M. Ehrhart, Naval Reserve

NEPMU-5

HMC T. Minor, released from active duty

NEPMU-6

None

NEPMU-7

None

From the S. E. A. NEPMU 6

Aloha from a somewhat soggy island paradise! As many of you may know- NEPMU 6 is not new territory for me. This is actually my second tour, though my job here this tour is quite different from the first. I am excited to be back and glad to return to the operational side of the house.

Now don't get me wrong. I totally enjoyed my 3.5 years as an instructor at Naval School of Health Sciences (NSHS), Portsmouth for Independent Duty Corpsman (IDC). Regardless of what any of you preventive medicine technicians PMTs have heard, IDCs aren't all that bad. I met some terrific IDCs at NSHS, and I learned tremendous lessons from many of them. A couple that I'd like to mention right now are:

HMCS(SW) Greg Marlatt, my friend and alter-ego. He is by far the finest Chief Petty Officer and Hospital Corpsman I have ever met. Anyone not sure of what direction they should head in need only ask HMCS Marlatt; He will be glad to point you towards success.

HMCS(SW/AW) Gloria McCuiston, a true keeper of Naval history and one of the most dedicated educators ever to grace the halls of any naval training facility. All of you IDC students

whining about pharmacy can stop.

HMC(AW) Marc Grose; no he's not an IDC, he's a Lab Tech. But absolutely one of the finest young Chief Petty Officers around and a great human being. We should raise a whole generation of Chief Petty Officers just like him. OK- maybe not exactly!

HM1(SW) Tina Pantaleo- again not an IDC, a Rad Health Tech. Definitely one of the Navy's hardest chargers. Dedicated, concerned and motivated to carry our navy into the 21st century. Tina has returned to the Fleet aboard the USS Emory S. Land, and I fully expect to see her name on the Chiefs' list very soon.

There are many, many more great people at NSHS Portsmouth- too many to name. You know who you are; keep working hard, the navy's future is in your hands.

HMCS(FMF) CHERI L. INVERSO

clinvers@hq.pacom.mil

Senior Enlisted Advisor, NEPMU 6

Fleet Public Health

Postmaster: send address changes to OFFICER IN CHARGE, NEPMU-5, ATTN FPH EDITOR, NAVSTA BOX 368143, 3035 ALBACORE ALLEY, SAN DIEGO CA 92136-5199